Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3855NSP	A. BUILDING _____ B. WING _____	09/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
U S NURSING CORPORATION	1516 EAST TROPICANA AVENUE, SUITE 237 LAS VEGAS, NV 89119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 000	INITIAL COMMENTS Surveyor: 22048 This Statement of Deficiencies was generated as a result of a State Relicensure Survey conducted in your facility on August 13, 2009 and finalized on September 28, 2009, in accordance with Nevada Administrative Code, Chapter 449, Nursing Pools. A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified:	P 000		
P 043	449.7473 USE OF LICENSE 1. Each license is separate and distinct and is issued to a specific person to operate a nursing pool at a specific location. A nursing pool must be operated and conducted under the name and within the area of service designated on the license. The name of the person who is	P 043		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3855NSP	A. BUILDING _____ B. WING _____	09/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
U S NURSING CORPORATION	1516 EAST TROPICANA AVENUE, SUITE 237 LAS VEGAS, NV 89119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 043	Continued From page 1 designated as responsible for its conduct must appear on the face of the license. This Regulation is not met as evidenced by: Surveyor: 22048 Based on observation, documentation review and interview, the facility failed to operate a nursing pool facility at the location documented on the license by the Administrator documented on the license in accordance with Chapter 439 and 449 of the Nevada Revised Statutes and the Nevada Administrative Code and the standards, rules and regulations adopted by the Board of Health. A survey was attempted on 9/28/09 at the location listed on the License. There were no staff members present in the office and the office did not appear to be in operation. Interview with the corporate office personnel, by phone, confirmed that the office was not operational and that a local contracted staff person checked on the officer every one to two weeks. Scop: 3 Severity: 3	P 043		